ANGIOTENSIN RECEPTOR BLOCKERS and DIURETICS PA SUMMARY

PREFERRED	Avalide, Benicar HCT, Hyzaar, Diovan HCT, Micardis HCT
NON-PREFERRED	Atacand HCT, Teveten HCT

LENGTH OF AUTHORIZATION: 1 Year

NOTE: *All current Atacand HCT and Teveten HCT users were grandfathered at the time of initiation of this PA criteria.*

PA CRITERIA:

- Use of 2 preferred agents in the past 6 months

OR:

- Submit documentation of allergies, contraindications, drug-drug interactions, or show a history of intolerable side effects to 2 of the preferred agents.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **SXC Health Solutions at 1-866-525-5827.**

PA and APPEAL PROCESS:

- For online access to the PA process please go to www.ghp.georgia.gov, select the Provider Information tab, click on "view full text" in the Pharmacy Services box, click on "Prior Approval Process" in the list on the left.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limit please go to www.ghp.georgia.gov, select Provider Information, click on "view full list" in the Medicaid Provider Manuals box then select Pharmacy Services from the list shown.